REPORT TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

ON

FIRST LEVEL COMMITMENT PILOT PROGRAM

Session Law 2003-178
House Bill 883

November 28, 2006

NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Report on First Level Commitment Pilot Program

November 21, 2006

Executive Summary: This pilot study evaluated 397 cases involving patients under a commitment petition who received first examinations between January 23 and February 27, 2006. The study found

History: In June 2003, the North Carolina legislature passed Session Law 2003-178, House Bill 883, that directed the Secretary of Health and Human Services to develop a pilot program allowing up to five Local Management Entities (LME's) to waive the current general statutes pertaining to the first level examinations for involuntary commitments performed by physicians and eligible psychologists. The pilot program permitted "*a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first level) examinations of individuals meeting the criteria for commitment in G.S. 122C-261(a) or G.S. 122C-281(a)*".

The five LME's that were selected by the Secretary were:

1) CenterPoint Human Services
2) Crossroads Behavioral Healthcare
3) Pathways MH/DD/SAS
4) Smoky Mountain Center
5) Piedmont Behavioral Healthcare

The legislation specified that a group of stakeholders would be involved to advise the Secretary in the development of staff competencies and privileges. This group included representatives from the following organizations.

- National Association of Social Workers
- North Carolina Council of Community Programs
- North Carolina Medical Society
- North Carolina Nurses Association
- North Carolina Psychiatric Association
- North Carolina Psychological Association
- North Carolina Society for Clinical Social Work
- North Carolina Substance Abuse Professional Practice Board

In addition, there were representatives from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) as well as from the pilot LMEs.

Representatives from this stakeholder group began meeting in October 2003 and devoted a great deal of time to the development of a privileging/supervision plan as well as a training curriculum. This plan outlined the procedure for supervising and privileging the masters level

staff performing these evaluations. The following are some of the work products competed by the stakeholders.

- Review of similar commitment activity in other states
- Review of other existing commitment training programs in other LMEs
- Development of the minimum elements for the training
- Training and qualifications of the trainers
- Role of psychiatrist in training (medical)
- Mandatory physician consultation if person is to be released (petition broken)
- Requirements for the supervision of masters level staff
- Review of data from pilot sites

Review of similar commitment activity in other states: A subcommittee of the stakeholders performed a search of the literature to determine what other states had done regarding commitment examinations and the use of various levels of staff to perform these examinations. What was found was that very little empirical research had been done to investigate the effect of allowing non physician or psychologist providers to perform commitment evaluations.

Review of other existing commitment training programs in other LMEs: This review did not find any such formal training programs from which the stakeholders could draw material.

Development of the minimum elements for the training: A subcommittee of the stakeholders met over several months and developed a comprehensive competency based training curriculum outline that set forth each of the elements that should be covered as the LMEs train masters level staff to perform commitment evaluations. It should be noted that this curriculum was very detailed and it was the group's consensus that this curriculum provided a more in-depth training pertaining to commitment than is currently being offered to any group.

Training and qualifications of the trainers: Using the curriculum developed by the stakeholders, the pilot LME's developed a two day training course and an examination based on the curriculum and then identified professional staff eligible to conduct these first level commitment examinations under this legislation. Fifty-nine staff were trained and successfully passed a comprehensive competency based the examination with a minimum score of 80 percent. Each LME was required to develop a separate plan for implementing the waiver; thus, the LMEs did not have the same implementation plans.

Role of psychiatrist in training (medical): In order to assist these non-medical staff in recognizing medical issues, a part of the training was developed and taught by physicians.

Mandatory physician consultation if person is to be released (petition broken): If the masters level staff person was considering releasing a person under a commitment petition, this pilot program required that they consult with and obtain approval from a physician or psychologist supervisor.

Requirements for the supervision of masters level staff: To further ensure that no harm would come to NC citizens during this pilot program, the stakeholders developed supervision and

privileging plans that included a detailed description of the supervision required of the masters level staff performing commitment examinations.

Review of data from pilot sites: The stakeholders participated throughout the pilot program in reviewing data and advising the pilot sites as well as the Division.

Evaluation Plan: The bill also directed the Secretary to *"evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver"*. Furthermore, it required the Secretary to *"send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services on or before July 1, 2006"*.

An initial evaluation plan was developed in December 2003. Pilot LME's began collecting data using the initial questionnaire as soon as they became operational. Below is a list of the dates each pilot LME began operation.

- Smoky – March 2004
- Piedmont – November 2004
- Crossroads – August 2005
- CenterPoint – August 2004
- Pathways – July 2004

After reviewing the data collected from the initial questionnaire, the Stakeholders recommended making the following changes in the evaluation.

- Include comparison sites in the study;
- Develop additional methodology for the follow-up phase of the study; and
- Collect more data that could be used to take into account differences between the staff and the LMEs in the study

In response to stakeholder recommendations, a more experienced evaluator was found for the study, and the following changes were made in the evaluation plan.

- Two LMEs (Durham and Eastpointe) were recruited to serve as comparison sites for the study
- The follow-up phase of the study was redesigned; and
- A more comprehensive questionnaire was developed to collect data at the pilot and comparison sites.

The revised evaluation plan was reviewed by the stakeholders and the pilot LME's and was revised in accordance with their suggestions. The result was an intensive 90 day evaluation period utilizing the redesigned questionnaire beginning on January 23, 2006. This report represents the findings from this data. These findings are consistent with the original data collected during 2004 and 2005.

There were four primary questions that this pilot program attempted to answer. These were:

1. Does having masters trained professionals performing first level commitment examinations result in individuals being committed when they should not have been committed?

2. Does having masters trained professionals performing first level commitment examinations result in individuals not being committed when they should have been committed?

3. Does having masters trained professionals performing first level commitment examinations result in increased harm to either the person being petitioned for commitment or others?

4. Does having masters trained professionals performing first level commitment examinations result in significant medical issues not being recognized and addressed?

Findings: Useable data were obtained on 397 patients who were under commitment petition and received first examinations between January 23 and February 27, 2006. There were 246 cases seen at the pilot sites and 151 cases seen in the comparison sites. The largest single portion of this data came from the Smoky Mountain Center where data was collected on 135 patients.

Table 1 displays data on all of the preliminary examinations conducted by staff at the pilot and comparison sites in the study. The top part of the table shows that masters level staff independently completed 90 of the preliminary examinations, and that masters and doctoral level staff jointly completed 156 of the examinations. We analyzed these data and found that there was also complete agreement between masters and doctoral level staff in terms of their recommendations for referring patients for second examinations.

The bottom part of Table 1 shows that 107 preliminary examinations were conducted by doctoral level staff at the comparison sites in the study. Only doctoral level staff were permitted to conduct these examinations at these sites. Thus, no data are presented in the columns in the table for "masters only" staff and both masters and doctoral level staff.

Tables 2 through 5 present data on the legal and treatment dispositions from preliminary examinations conducted at the pilot and comparison sites in the study.

Table 2 shows that the percentage of patients released (i.e., not referred for second examinations) ranged from 35.4% for the pilot sites to 36.4% for the comparison sites. Alternatively, the percentage referred for second examinations ranged from 63.6% for the comparison sites to 64.6 % for the pilot sites.

It is important to note that the vast majority of the 87 individuals from the pilot sites and the 39 from the comparison sites that were released were not sent home without treatment. The majority were referred to some inpatient or outpatient treatment setting. It was not uncommon to

"release" the person from the involuntary commitment petition yet admit the person to a community hospital or crisis center on a voluntary basis. Thus the person is not really released in terms of treatment even thought they are released from the legal perspective.

Table 3 shows data on treatment dispositions from the preliminary examinations. It can be seen from this table that 70.3 % of the patients at the pilot sites and 65.4% at the comparison sites were referred for inpatient treatment. Alternatively, 23.6% of the patients at the pilot sites and 18.7% of those at the comparison sites were referred for outpatient treatment.

The Preliminary Report for this study focused on 64 patients where their preliminary examination involved both masters and doctoral level staff. Those data showed there was no difference between these staff in terms of recommendations from their preliminary examinations. A similar analysis of data on 156 patients who had been examined by both masters and doctoral level staff was conducted, and the data showed the same results as the earlier study. Thus, it appears that other factors are more likely to account for variations in legal and treatment dispositions from preliminary examinations.

Table 4 displays data on both the legal and treatment dispositions from the preliminary examinations. Overall, this table shows that close to two-thirds of the patients were referred for inpatient treatment, one-third were referred for outpatient treatment, and that a small percentage (6.1% for pilots and 10.3% for comparisons) were referred for other treatment or were not referred for treatment.

This study found that there was strong agreement between masters and doctoral level staff in terms of patients recommended for second examinations. However, while staff may agree on which patients they recommend for second examinations, this does not mean that they made the right recommendations for those patients. Consequently, we analyzed data on the legal dispositions of the patients referred for second examinations. These examinations are usually conducted by highly qualified medical staff at community or state psychiatric centers, and thus they can provide an objective means for assessing the quality of referrals from preliminary examinations.

Table 5 displays data on legal dispositions from second examinations conducted on patients referred from the pilot and comparison sites in the study. The choice at this point in the commitment process allows for the physician performing the second level examination to agree with the first level examiner and commit the person or to determine that the person does not meet the criteria for commitment and release the person from the commitment petition. Table 5 shows that the percentage of commitments ranged from 81.3% for Crossroads to 100% for Centerpoint. While the percentage of commitments was lower for the comparison site (Durham) than for the pilot sites (76.7% vs. 89.4%) these sites are unlikely to be truly comparable due to differences in their service providers and consumers. Nonetheless, the data suggest that staff at both the pilot and the comparison sites did an exemplary job in screening and referring patients for second examinations.

A review of adverse events recorded on follow-up did not find a difference in events between masters or doctoral level staff. However, the size of this sample combined with the rarity of

adverse events does not permit this study to draw any conclusion from this data. The sample size in this study was too small to allow for a statistically significant finding. A review of missed medical data also did not allow for conclusions but the few events were found with both the doctoral and masters level evaluators.

Table 1: Preliminary Examinations Conducted by Masters and Doctoral Level Staff at Pilot and Comparison Sites in Study

	Staff Who Conducted Preliminary Examinations							
	Masters-Only[1]		Doctoral-Only		Both[2]		Total	
Pilot Sites	N	%	N	%	N	%	N	%
Centerpoint	8	8.9%	0	0.0%	5	3.2%	13	5.3%
Crossroads	14	15.6%	0	0.0%	33	21.2%	47	19.1%
Pathways	3	3.3%	0	0.0%	17	10.9%	20	8.1%
Piedmont	5	5.6%	0	0.0%	26	16.7%	31	12.6%
Smoky Mt.	60	66.7%	0	0.0%	75	48.1%	135	54.9%
Total	90	100.0%	0	0.0%	156	100.0%	246	100.0%

	Staff Who Conducted Preliminary Examinations							
	Masters-Only[3]		Doctoral-Only		Both[3]		Total	
Comparison Sites	N	%	N	%	N	%	N	%
Durham	0	0.0%	70	65.4%	0	0.0%	70	65.4%
Eastpointe	0	0.0%	37	34.6%	0	0.0%	37	34.6%
Total	0	0.0%	107	100.0%	0	0.0%	107	100.0%

Protocol used for Preliminary Examination at Pilot Sites in Study

1. Masters-level staff permitted to make final determination for preliminary examinations only when they recommended patient for second Examination
2. All recommendations made by Masters-level staff for "release" were reviewed by Doctoral Level staff, who made the Final Determination
3. North Carolina Law permitted Masters Level Preliminary Examinations only at Pilot Sites

Table 2. Legal Dispositions from Preliminary Examinations Conducted at Pilot and Comparison Sites in Study

	Legal Dispositions from Preliminary Examinations				
Pilot Sites	Number Referred for Second Examinations	Percent Referred for Second Examinations	Number Released After Preliminary Examination[1,2]	Percent Released After Preliminary Examination	Total
Centerpoint	5	38.5%	8	61.5%	13
Crossroads	26	55.3%	21	44.7%	47
Pathways	11	55.0%	9	45.0%	20
Piedmont	21	67.7%	10	32.3%	31
Smoky Mt.	96	71.1%	39	28.9%	135
Total	159	64.6%	87	35.4%	246

	Legal Dispositions from Preliminary Examinations				
Comparison Sites	Number Referred for Second Examinations	Percent Referred for Second Examinations	Number Released After Preliminary Examination	Percent Released After Preliminary Examination	Total
Durham	44	62.9%	26	37.1%	70
Eastpointe	24	64.9%	13	35.1%	37
Total	68	63.6%	39	36.4%	107

Notes:

1. Includes 14 voluntarily admissions to inpatient psychiatric facilities
2. Includes three Outpatient Commitments (release pending count hearing)

Table 3. Treatment Dispositions from Preliminary Examinations

Conducted at Pilot and Comparison Sites in Study

	Treatment Dispositions from Preliminary Examinations						
Pilot Sites	Number Inpatient[1]	Percent Inpatient	Number Outpatient	Percent Outpatient	Number Other[2]	Percent Other	Total Exams
Centerpoint	9	69.2%	3	23.1%	1	7.7%	13
Crossroads	29	61.7%	14	29.8%	4	8.5%	47
Pathways	14	70.0%	4	20.0%	2	10.0%	20
Piedmont	18	58.1%	12	38.7%	1	3.2%	31
Smoky Mt.	103	76.3%	25	18.5%	7	5.2%	135
Total	173	70.3%	58	23.6%	15	6.1%	246

	Treatment Dispositions from Preliminary Examinations						
Comparison Sites	Number Inpatient[1]	Percent Inpatient	Number Outpatient	Percent Outpatient	Number Other[2]	Percent Other	Total Exams
Durham	46	43.0%	16	15.0%	8	11.4%	70
Eastpointe	24	22.4%	4	3.7%	9	24.3%	37
Total	70	65.4%	20	18.7%	17	15.9%	107

Notes:

1. Includes patients referred for second examinations, Crisis Beds, and Homes for Assisted Living

2. Includes patients who were not referred

Table 4. Legal and Treatment Dispositions from Preliminary Examinations

Conducted at Pilot and Comparison Sites in Study

Pilot Sites	Legal Dispositions from Preliminary Examinations					
Treatment Dispositions	Number Referred for Second Examination[1]	Percent Referred for Second Examination	Number Released After Preliminary Examination[1]	Percent Released after Preliminary Examination[1]	Total	Percent
Inpatient Treatment	159	64.6%	18	7.3%	173	70.3%
Outpatient Treatment	0	0.0%	58	23.6%	58	23.6%
Other Treatment/ Not Referred	0	0.0%	15	6.1%	15	6.1%
Total	159	64.6%	87	35.4%	246	100.0%

Comparison Sites	Legal Dispositions from Preliminary Examinations					
Treatment Dispositions	Number Referred for Second Examination[1]	Percent Referred for Second Examination	Number Released After Preliminary Examination[1]	Percent Released after Preliminary Examination[1]	Total	Percent
Inpatient Treatment	68	63.6%	2	1.9%	70	65.4%
Outpatient Treatment	0	0.0%	26	24.3%	26	24.3%
Other Treatment/ Not Referred	0	0.0%	11	10.3%	11	10.3%
Total	68	63.6%	39	36.4%	107	100.0%

Notes:

1. Includes patients referred for second examinations
2. Includes 6 patients with outpatient commitments (release pending court hearing

Table 5. Legal Dispositions from Second Examinations Conducted at Pilot and Comparison Sites in Study

	Legal Dispositions from Second Examination				
Pilot Sites	**Number Referred**	**Number Missing Data**	**Number Having Data**	**Number Committed[1]**	**Percent Committed[2]**
Centerpoint	**5**	**1**	**4**	**4**	**100.0%**
Crossroads	**26**	**10**	**16**	**13**	**81.3%**
Pathways	**11**	**0**	**11**	**10**	**90.9%**
Piedmont	**21**	**1**	**20**	**18**	**90.0%**
Smoky Mt.	**96**	**5**	**91**	**82**	**90.1%**
Total	**159**	**17**	**142**	**127**	**89.4%**

	Legal Dispositions from Second Examination				
Comparison Sites	**Number Referred**	**Number Missing Data**	**Number Having Data**	**Number Committed[1]**	**Percent Committed[2]**
Durham	**44**	**1**	**43**	**33**	**76.7%**
Eastpointe[3]	**24**	**0**	**0**	**0**	**0.0%**
Total	**68**	**1**	**43**	**33**	**76.7%**

Notes:

1. Based on data collected by study and data available from HEARTS

2. Based on number having data on second Examination

3. No second Examination data available for Eastpointe

Statements Supported by the Data: The following statements are supported by the data.

- When examining the same patients, masters as well as doctoral level staff make the same recommendations about whether to release or commit patients.

- When examining different patients within the same LME, masters as well as doctoral level staff appear to make the same recommendations about whether to release or commit patients.

- Given that both masters and doctoral level staff make the same recommendations regarding commitment or release, it is expected that the clinical outcomes would be similar.

- It appears that the availability of community resources is the determining factor in whether or not the patient is sent to a secure State Psychiatric or Substance Abuse facility or placed in their local community.

- There was no evidence found to suggest that masters level staff perform first level commitment examinations differently than doctoral level staff.

- There is a great deal of variability in the commitment process and outcome depending on the LME involved.

Discussion: At the outset, the evaluation of the First Level Commitment Pilot Program attempted to address the following four questions. Each question is listed below followed by a discussion.

1. ***Does having masters trained professionals performing first level commitment examinations result in individuals being committed when they should not have been committed?*** The data in the study indicates that the pilot sites send patients for a second level commitment examination at the same rate as do the comparison sites. The percent of time the patient is committed following the second level examination is higher for the pilot sites (89.4% vs. 76.7%) suggesting that masters level staff are at least as accurate at making the correct commitment decision in referring patients for the second level examination. The comparison site (Durham) in this study having follow up data may not be representative thus one can not generalize to say that masters level evaluators are more accurate in making commitment decisions.

2. ***Does having masters trained professionals performing first level commitment examinations result in individuals being released when they should have been committed?*** As noted earlier, the scope of the study precludes any definitive answer to this question. However, due to the design of the study, no masters level clinician released anyone without the review and approval of a doctoral level supervisor. Therefore, if an individual was released when they should have been committed the doctoral level staff concurred with the release. This study is not able to answer with certainty that masters level clinicians release only when appropriate as the study's design did not allow for

independent review of masters level staff commitment decisions by highly trained and experienced doctoral level individuals. However, no data was found to suggest that the persons being released by masters level staff should have been committed. In terms of referring for commitment, the data shows that the masters level staff have a higher rate of agreement with the decision of the second level evaluator than do the physician evaluators.

3. ***Does having masters trained professionals performing first level commitment examinations result in increased harm to either the person being petitioned or others?*** As noted earlier, the scope of the study did not permit this question to be definitively answered. This study did not produce any evidence to suggest that there were more adverse events among patients released by masters level clinicians then by the doctoral level staff at the comparison site. There were few adverse events reported and there were no significant differences between masters versus doctoral level staff.

4. ***Does having masters trained professionals performing first level commitment examinations result in significant medical issues not being recognized and addressed?*** The small sample size and the rarity of such medical problems make answering this question impossible with the current study. However, this study found no evidence that significant medical issues were missed by masters level clinicians. In fact, the very few incidences reported were divided among masters level and physician evaluators.

The study began with the evaluators having the hypothesis that masters level staff would release more individuals than doctoral level clinicians. This hypothesis was based on the belief that the masters level evaluators would be placing individuals in community settings more frequently and that ER physicians would be more likely to pass the patient on to the second level evaluation. In fact, pattern of release following the first level examination was the same for both groups and the primary factor in deciding whether a person is committed or released appears to be the presence of appropriate community resources.

Both the pilot and comparison sites sent patients to inpatient and outpatient settings at approximately the same rate. However, the comparison sites released slightly more individuals to other forms of treatment or released without a referral.

There was a great deal of variability among LMEs suggesting that there are a range of factors effecting the outcome of commitment evaluations but it does not appear that the educational level of the staff performing the evaluation is a significant factor. The various LME processes and procedures surrounding involuntary commitments may be an important factor in accounting for this variability. In addition, the differences among state hospitals may also contribute to the variability.

It appears that the high level of agreement among masters and doctoral level clinicians seeing the same patient may be due to the following factors.

- The very thorough training program developed by stakeholders and pilots
- The high level of competency required to pass the examination

- The supervision that all masters level staff obtained following the examination.
- The doctoral level consultation required in all cases where the masters level staff person is considering releasing the individual from the commitment following the first examination

The presence or absence of community resources seems to be the determining factor in whether a masters or doctoral level professional performing a first level commitment examination can send the individual to treatment in their local community versus having to transport the individual to a state psychiatric hospital or to an Alcohol and Drug Abuse Treatment Center. Sites in this study having access to community crisis beds were able to appropriately divert commitments from state facilities.

Recommendation: This study found that masters and doctoral level staff make similar commitment decisions. Community resources, differences among LMEs, and possible differences among state hospitals appear to be the factors most affecting the commitment process and outcome. The design of the pilot helped to assure that safety was secured by requiring masters level professionals planning to release the individual from a commitment petition obtain consultation and approval from a doctoral level professional. Therefore, the following are recommendations based on the evaluation of the First Level Commitment Pilot Program.

- It is recommended that this pilot be expanded statewide to allow clinical social workers, psychiatric nurses, and clinical addictions specialists to perform first level commitment examinations.

- To accomplish this, it is recommended that General Statutes 122C-261-263 and 281-283 be amended to allow an eligible clinical social worker, and eligible psychiatric nurse, and an eligible clinical addictions specialist to perform the initial (first level) commitment examination. Definitions for each of these professions could be added to the General Statutes to include a licensed clinical social worker, a psychiatric mental health clinical nurse specialist in advance practice, a psychiatric mental health nurse practitioner, or a masters level licensed clinical addictions specialist. To be eligible, these professionals would be required to complete a uniform training course, pass an approved examination, have approved supervision, and obtain approval from doctoral level staff person prior to releasing an individual from a commitment petition.

- If this pilot is expanded, it is recommended that there be some identifier given to individuals eligible to perform these first level commitment examinations so that facilities accepting involuntary commitments will know who is qualified to sign the involuntary commitment examination form. In addition, it is recommended that the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) maintain a registration of these new professionals eligible to perform first level commitment examinations.

Respectfully Submitted,
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